SUICIDE PREVENTION

INFORMATION FOR WOMAN AND CHILD DEVELOPMENT ORGANIZATIONS

National Institute of Mental Health and Neuro Sciences
Bangalore - 560 029,
India

NIMHANS/EPI/SUI.Prevn/Women & Child.2003

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FOREWORD

Mankind marches ahead in its quest for growth and development : the changing social, economic and health pattern of societies is a living testimony to this growth and development. Suicide, an index of disturbed society is one of the leading causes of morbidity, mortality, socioeconomic losses and diminished quality of life. There have been some efforts by Indian researchers to understand this problem in its various dimensions and much more needs to be done.

It is shocking to note that nearly 1,10,000 persons completed suicides in India and Bangalore city alone has been recording more than 1500 suicides every year. Nearly 10-20 times this number have attempted and lakhs of people would have passed through suicidal thoughts. This complex problem is often an interplay of various health, social, economic and cultural factors, specially in a country like India experiencing poverty, illiteracy and ignorance.

Undoubtedly, suicide prevention is everyone's business in every society. Only an integrated, coordinated, intersectoral approach in a scientific manner is likely to yield results. The departments of Epidemiology and psychiatry undertook population based and hospital based research in this area, resulting in a greater body of knowledge for prevention programmes. Following research, Gururaj and Mohan Isaac initiated a series of capacity building workshops for doctors and hospital administrators, NGOs in health care, educational institutions, police and legal officers, child and women development organizations and media professionals. The perspectives, impressions and recommendations of these workshops are being brought out as "Information" handbooks for these professionals. These books should guide our Policymakers and professionals in developing national suicide prevention policy on a scientific approach with the involvement of everyone working in this area. I strongly urge the Indian society to consider suicide prevention as a major agenda of the present decade to save our precious human resources.

❖ **D. Nagaraja**
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PREFACE

Suicides are now recognized as a public health and social problem in every country, including India. Suicides have been on the increase in every part of India, in both urban and rural areas. As per National Crime Records Bureau reports, the city of Bangalore has been recording highest number of suicides for several years. Wide variations have been noticed in suicide problem and pattern in several parts of the country. The complex and cumulative interaction of social, health, cultural, economic and environmental factors are known to result in suicides. As majority of suicides happen in the young and productive segments of society, it is a phenomenal loss to developing societies.

Even though the problem is on the increase, a scientific understanding of the problem has not been attempted in a major way. National Institute of Mental Health and Neuro Sciences recognized the problem during 1995 and initiated a major study in the city of Bangalore. A large scale and indepth population based study was undertaken to unfurl the epidemiological dimensions of suicides. Two reports entitled "Epidemiological of Suicides in Bangalore" and "Suicides ....beyond numbers" are available to readers, providing scientific details. Simultaneously, the Ministry of Health and World Health Organization, South-East Asia Regional Office facilitated the study on "Risk factors for completed and attempted suicides" in Bangalore. This work has been completed and results are available to researchers, policy makers and public health administrators.

Dissemination of research results, capacity building process and development of intervention programmes are urgently required for prevention of suicides. As causes of suicides are several, interventions must be intersectoral. Prevention programmes require the participation of professionals from health, education, social welfare, commerce, industries, excise, media and others to initiate programmes. However, it was felt that there is need for awareness programmes, sensitization of issues, consensus building and identifying key components for prevention within each sector.

With this in view, NIMHANS initiated and completed a series of workshops for doctors and health administrators, family physicians, NGOs in mental and general health, heads of educational institutions, police and legal professionals, child and women development organizations and media personnel. In each of the workshops,

researchers and other prominent people shared their opinions while participants deliberated and identified key areas of activity. The issues, discussions, recommendations and activity components have been summarized in these 7 reports as "information documents"; viz 'Information for Health Professionals', 'Information for Non-Governmental Organizations', 'Information for Educational Institutions', Information for Family Physicians', Information for Police Personnel', 'Information for Woman and Child Development Organizations', and 'Information for Media Professionals'. Each document has been organised into 3 parts. First section provides an overview of suicides in Bangalore focusing on the problems, causes, impact, neglect of suicides, role of intersectoral approach and capacity building measures. Section 2 delves in detail on various issues discussed during the workshop and remedial measures for action. Details of the workshop and participants are provided in Section 3. To maintain uniformity, section 1 is common in all reports and the remaining 2 sections are unique for each of the workshops.

Undoubtedly, these information documents are not a prescription but a proposition. It shows the possibility of wide variety of interventions to be considered - prioritized - implemented within and across different sectors. The suggested mechanisms are aimed at reducing suicides in general, while focussing on the problem in different societal groups. It is our hope that 5 P's - Politicians, Policy makers, Professionals, Public and Press of society recognize the problem and initiate activities.

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We gratefully acknowledge the inputs and contributions of Dr. Ranjani Ramanujam, Senior Research Officer, under the project 'Identification of risk factors and capacity building measures for prevention of suicides'. Her valuable inputs in preparation for the workshops, handling correspondence, summarizing the proceedings and development of the manuscript is sincerely acknowledged.

Our sincere appreciation and thanks to Dr. Suryanarayana S.P., Dr. Girish N., Mr. Vijendra Kargudri, Mr. Srinivasan C., Mr. Govinda Raju, Mr. Srinivasa Murthy, Mr. Chandrasekar & other research staff for their valuable inputs at several stages of the workshops.

1. INTRODUCTION

Health is a fundamental human right and a world wide social goal. An understanding of health and disease along with delivery of affordable quality health care is the basis of all health care. Health has evolved over the centuries as a concept from an individual concern to a world wide social goal and encompasses the whole quality of life. Health involves individuals, state and international responsibility and its promotion is a major social investment. The purpose of health services is to improve health status of the population and is essential for social and economic development. Health services must be designed to meet the health needs of the community through the use of available knowledge and resources.

The health sector has been striving to improve health of people and to usher in a better quality of life among individuals. Historically, societies have strived to achieve better health status through a number of medical advancements along with improvements in education, income levels, better access to quality health care and improving quality of services. However, a large number of people in the country are still far placed in receiving even the minimum services. Nevertheless, over a period of time gross mortality and morbidity have changed resulting in a decline of death rates. Significantly, the burden of disease has been changing and now mankind is facing a combination of communicable, non communicable diseases and injuries.

The word "Suicide" first used by Sir Thomas Brown in 1642 in his "Religio medici" has evoked a variety of reactions in public minds. These reactions vary from anger, distress, ridicule, anxiety, tension, fear, sadness and stigma. Suicide, as such means, "an intentional determination to end one's life, an unexpected way of death, where the willingness to die originates within the person and there is the presence of known or unknown causes to end one's life". Suicide whether completed, attempted or considered, is also a state where available options and future possibilities are never considered before the act. Throughout history, the word 'Suicide' has had different meanings to different people. Various meanings attributed to the term include "The murder of oneself", "nothing less than a (sort of) exit", "an end to psychic conflicts", "a conscious act of self-inflicted cessation"; "an act of despair of which the result is not known, occurring after a battle between

an unconscious death wish and a desire to live better", "to love and be loved", "to live or not to live" and others. The term 'Parasuicide is referred to non-fatal acts in which an individual deliberately causes self-injury. In whatever way the word is defined and understood, undeniably it is an act of self-destruction and a major loss to the society.

There is considerable debate all over the world as to why people commit suicide, since self-destruction of human beings has always been a matter of curiosity. Since suicide is an act of killing oneself performed by the person with his/ her full knowledge, and knowing fully well the results of the final outcome, it is always considered something very close to the person committing the act. The various causes for a suicide are by and large many and complex, ranging from social, economic, health, cultural, political, religious and other areas of an individual's life. Recent research indicates that suicides are multifactoral in nature, cumulative due to number of causes which are progressive and operate over a period of time. A small percentage of impulsive suicides have been extremely difficult to understand. Since causes are multifactoral, several options are also considered in prevention of suicides.

The creation and destruction of mankind has been a matter of intense intrigue for many years. In recent years, the emerging self-directed violence or suicides and destruction by others or homicides for a wide variety of reasons has been a matter of debate across the world. Voices are emerging from every corner of the globe to understand and prevent or reduce the same in every country. What drives a person to the ultimate state of self-destruction or deliberate self-harm has baffled scientists, researchers, priests, philosophers, lawyers, doctors, social workers and others for decades. Suicide as an entity has cut across countries, societies and communities within geographical locations. No barriers of age, sex, class, religion exist in suicides. Suicide or deliberate self-harm, an event considered as more of a cultural or social phenomenon is recently recognized as a public health problem in every country. The phenomenon of suicides in the recent years has become so common that no single day passes without reading, hearing or watching an act or attempt in the media. Some recent headlines from the leading newspapers of Bangalore city indicate that it is a day-to-day event.

- July 31st, 2001: Deccan Herald: **Suicide:** Dejected over his wife and children walking out of his house, a 45-year-old man committed suicide by hanging at his residence in _____ police station limits on Sunday night.

- July 31st, 2001: Deccan Herald: **Suicide:** A 30 - year old woman committed suicide by setting herself ablaze in _____ police station limits. Poverty is said to have provoked her to take the extreme step, police suspect.

- August 3rd, 2001: Indian Express: **2 more farmers commit suicide:** Two farmers in Karnataka, unable to repay their debts, allegedly committed suicide in separate incidents. _____of _____ village in ____ district consumed pesticide at their fields on Wednesday. He was upset over not being able to repay his loans. Another peasant, ____, 48, of _____ village in _____ district also committed suicide by hanging himself on Tuesday from the roof of his pump house. He was not able to clear his loans amounting to Rs. 2 lakh, which he had incurred for drilling his bore wells.

- August 4th, 2001: Deccan Herald: **Dowry Death:** Unable to bear the alleged harassment for dowry by her in-laws, a newly married girl committed suicide by hanging in _____ police station limits on Wednesday night.

- August 7th, 2001: Deccan Herald: **College student commits suicide:** A II PUC student from _____ College committed suicide by hanging herself from a ceiling fan in hostel in _____ police station limits. Police suspect dejection in love to have provoked her to take the extreme step.

- August 8th, 2001: Deccan Herald: **Cop commits suicide over wife's chit business:** Affronted by his wife's refusal to close down her chit fund business, a police constable committed suicide by hanging at his residence in _____ police station limits in the wee hours of today. The deceased has been identified as _____, aged 40 years, a constable attached to the crime wing of the _____ police station in the city. On returning home last midnight, _____ got into a verbal argument with his wife while having dinner. Following this, _____ walked into one of the rooms, bolted the door from inside and hanged himself to the ceiling with two lungis.

- August 8th, 2001: Deccan Herald: **Suicide:** Following an argument with her mother-in-

law, a 28-year old woman committed suicide by setting herself ablaze in _____police station limits last night.

- August 9th, 2001: Deccan Herald: **Man commits suicide over 'harassment' at office:** Unable to bear the harassment from his company's management, a 28-year-old man, executive of a multi-national company dealing in electronic gadgets committed suicide by consuming poison at his residence in _____ police station limits.

- August 10th, 2001: Deccan Herald: **Newly-wed couple ends life in City hotel:** A newly-married couple from _____ committed suicide by consuming a huge dose of sleeping pills in a hotel room at _____ in the city. The deceased have been identified as _____ (23), a MBBS graduate and _____(19), a final year student of computer application course from _____. The couple were married two months ago. Police said the couple ended their lives after consuming around 150 Gardenal tablets which is a sleep inducing medicine. However, the exact motive for the extreme step is yet to be ascertained.

Myth: *A person attempting or completing suicide says "My time is over, God is calling me"*

Fact: *This is because of some personal beliefs. It might be the person's feeling that he or she has reached the end of life and nothing more can be done. Some people may be hearing voices or seeing images due to specific mental problems. Such responses by people should be taken seriously by people around him/her.*

- August 11th, 2001: Times of India: **The grass was not greener on the other side for her:** A case of dowry harassment has been registered against _____, a _____ settled in _____, for ill-treating his Indian wife that ultimately led her to take her own life in the city on July 29th.

- August 12th, 2001: Times of India: **Councilor commits suicide:** _____, the newly elected councilor from _____ CMC in _____ police station limits committed suicide by hanging herself from a ceiling fan at her mother's house in _____ on Saturday afternoon.

2. THE PROBLEM

In India, suicides are more of a medicolegal problem than a health or societal problem. Hence, information on suicides is collected and compiled by police departments. The health surveillance systems are still not established in the country. As health care institutions do not report on attempted suicides and presence of suicidal behaviours among care seekers, data on this is not available. Even the few studies in this area from health researchers and social scientists rely upon police sources. Given the complexities of reporting- investigation - analysis - utilization of information for inputs in policies and programmes and skills and competence of investigating authorities, the available information has major limitations.

In view of the medicolegal dimensions of suicides, it is understood that majority of the acts would get registered with police. However, all completed and attempted suicides are not registered with police due to fear, stigma and legal compliments. Nevertheless, with the absence of information on this problem from health sector, this will be the only available data till alternative and reliable systems come into effect.

Myth: *Only others commit suicide. It will not happen to me.*

Fact: *Majority of the people have a fleeting thought of ending his/ her life in a crisis situation, but not everyone pursues the thought. When such thoughts repeat continuously, increases in frequency and severity and, begin to affect day-to-day activities, suicides are likely to occur.*

Globally, it was estimated that nearly one million people died from suicide during the year 2000. In simple terms, this means one death every 40 seconds. In India, it is reported that nearly 1,10,587 people completed suicides during 1999 with a male to female ratio of 1.2:1, respectively. From nearly 68,744 suicides in 1989, the numbers increased to 1,10,587 by 1999 (Figure 1). During this year, 65,488 men and 45,099 women ended their lives in a tragic way. One suicide is reported every 5 minutes in the country. Nearly 70% of suicides occur in the age groups of 15-39 years (Figure 2). One in every three suicide victims was a youth

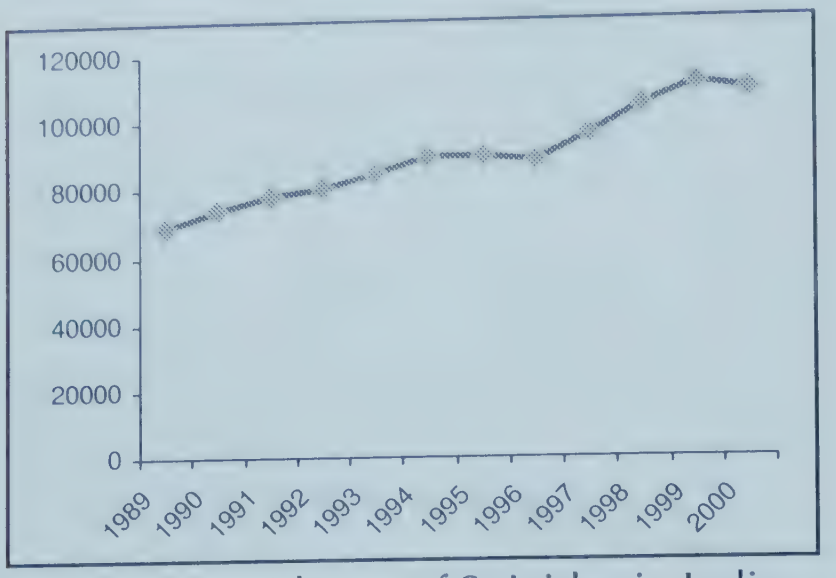

Figure 1: Incidence of Suicides in India from 1989-2000

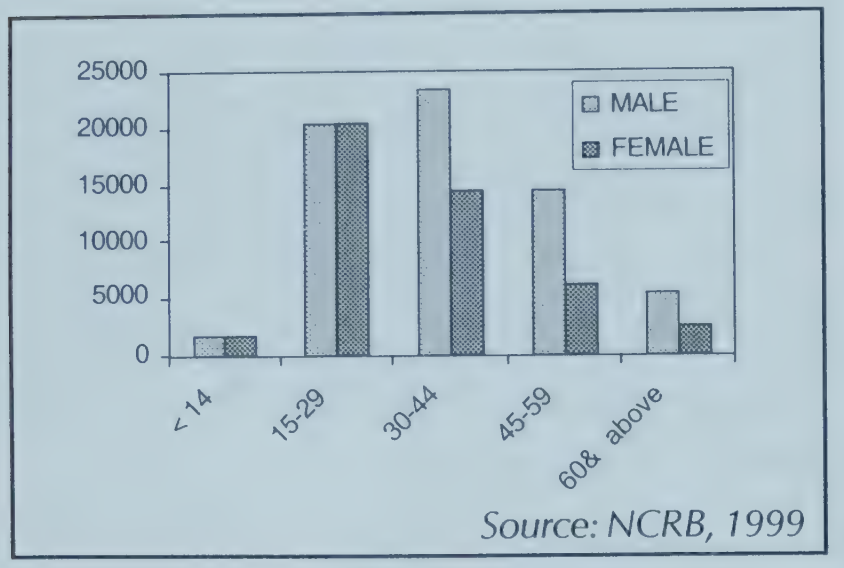

Figure 2: Age-Sex Distribution of Completed Suicides

Myth: *If a person has attempted suicide once, he will not repeat the same.*

Fact: *This is not true, It is known that attempters are likely to repeat/ complete the act in the first one or two years after the event. These persons need constant observation, an empathetic understanding and appropriate care. After a brief period of recovery, if the person goes back to contemplating death, he/she needs to be supported, observed and cared for.*

(15-29 years). More women committed suicides in their young ages compared with men. 61 housewives (as against 57 in 1997) on an average committed suicide in a day in the country. Significant regional variations are noticed with the states of Kerala, Karnataka, Maharashtra and West Bengal, accounting for nearly 50% of total suicides. The cities of Bangalore, Mumbai, Chennai and Delhi reported nearly 1,900, 1,400, 1,100 and 800 suicides, respectively, during 1999. Every day 3-4 suicides are reported from these cities. The common means adopted for suicides were hanging (25%), poisoning (37%), self immolation (11%) and drowning (9%). A number of factors in social, economic, cultural and health areas have been implicated in causation of suicides.

Karnataka is one among the top 5 states with highest suicide rates in India. During 1996 and 1997, 8,800 and 10,225 persons completed suicides, an increase of nearly 40%. During the year 2000, nearly 12,375 individuals completed suicides in the state (Figure 3). The male to female distribution was 60% and 40%, respectively. Persons in the age group of 15-29 years and 30-44 years contributed for 30% and 35%, respectively. The common methods of suicide were poisoning by organophosphorus compounds (42%), hanging (25%), drowning (15%) and self- immolation (10%). Various social, cultural, health related and economic problems have been identified as contributing factors for suicides.

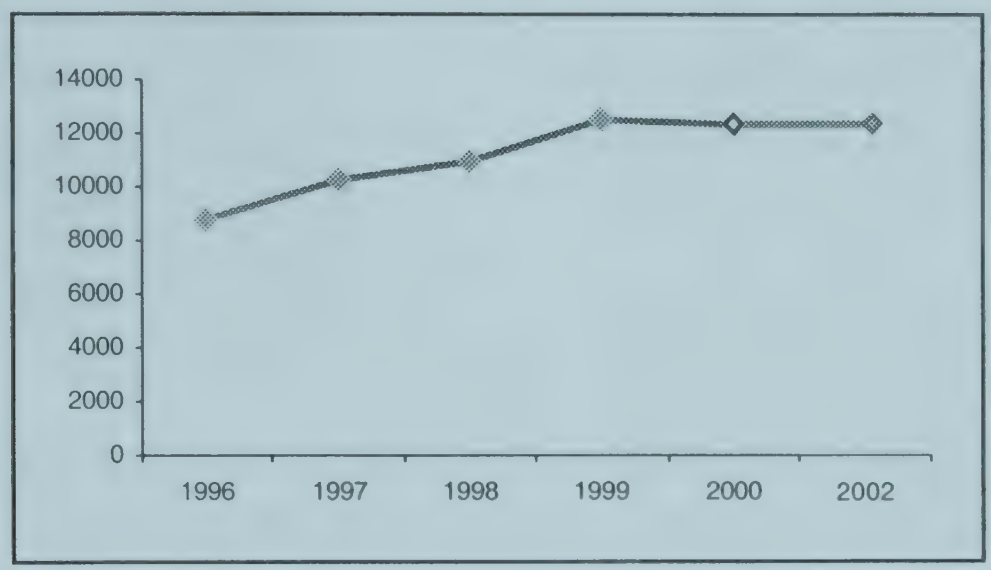

Figure 3: Incidence of Suicides in Karnataka from 1996-2002

The city of Bangalore has been growing at a phenomenal rate during the last decade. The city has been acclaimed to be a fast developing technological hub in South East Asian region and is one of the top cities in the world. The city with a population of nearly 6 million is also a place for witnessing changes in all spheres of life. The current suicide rate in Bangalore is around 34/1,00,000 population. The city has witnessed increasing suicides from nearly 500 in 1990 to about 1500 in 2002, an increase by 3 times (Figure 4). Highest number of suicides in the city occur in the age group of 15-29 years, with slightly higher rates among men compared with women. Among the common methods of suicides are hanging, poisoning and self-inflicted burns. A recent study undertaken by NIMHANS along with the City Police Department and 12 major hospitals has unraveled several dimensions of suicides in Bangalore (1, 2)

1. Gururaj G. & Isaac M.K., Epidemiology of Suicides in Bangalore, NIMHANS, Bangalore. Publication No. 43, 2001
2. Gururaj G. & Isaac M.K., Suicides ..... Beyond Numbers, NIMHANS, Bangalore. Publication No. 44, 2001

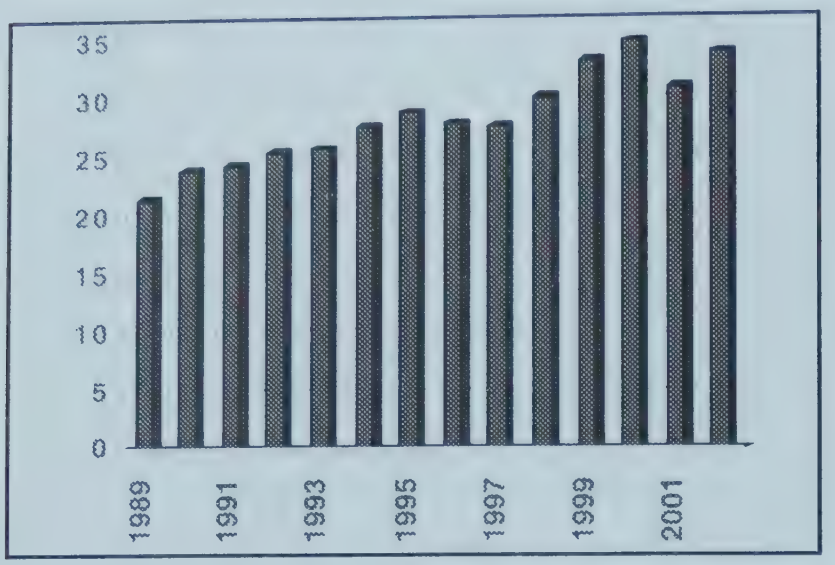

Figure 4: Suicides In Bangalore 1989-2000

Myth: *A person who talks about suicide does not commit it, but only threatens in order to draw attention.*

Fact: *While some people use minor degrees of self-harm to draw attention of people around them, most people give clues at some point by talking about the same. Such clues should be taken seriously.*

While completed suicides are generally reported to police due to medico legal requirements, attempted suicides are not reported to any agency, even though care is provided by all health care agencies. The number of people attempting suicides in Bangalore is not known since all attempted suicides are not reported to any agency. However, the ratio of completed to attempted varies from 10-20. It is estimated that nearly 19-20,000 persons attempt suicide in the city of Bangalore. The precise number of people with a suicidal thought is usually not known from general population. It is estimated that suicidal behaviours are more by 50-100 times, compared with completed suicides.

Myth: *It is not possible to identify a person likely to commit suicide. Nobody can suspect his/her intention.*

Fact: *This is not always true. Majority of people give a clue or warning sign or commit an act, which should be taken seriously (talking about death wishes, donating their belongings, writing sad stories, poems etc.).*

3. WHY DO PEOPLE COMMIT SUICIDE

This question has been baffling the minds of everyone connected with management and prevention of suicides. Suicides occur due to a number of social, economic, cultural, religious, health related and other factors. A recent large scale analysis of completed and attempted suicides in Bangalore has identified many factors. An ongoing case control study in Bangalore is expected to throw more light on causative mechanisms. In developing countries like India a number of factors related to culture, family life, education, growing aspirations and inability to tolerate negative feelings contribute in a big way for suicides. As per the words of RFW Dieksten (1989), "Suicide is a parasuicidal phenomenon. On the one hand it appears to be the most personal action an individual can take. On the other hand, it is ubiquitous, has occurred throughout human history in all corners of the world and often under circumstances that show such a striking similarity that one has but to conclude that social factors play an important, if not decisive role in it's causation".

In India and its cities, research has not progressed to understand the aetiology of suicides. Much of the research is based on analysis of police records, which has severe limitations from an analytical perspective. Preliminary analysis of police and hospital records from Bangalore indicate that suicides are associated with age, sex, education, occupation, marital status, living environment of the person, health status and many other factors. Further, specific - precipitating and triggering factors vary from person to person depending on the situation - mode - context and nature of the issue. Research over the last two decades has identified number of causes. Some prominent reasons found to have an association with suicides are events in one's interpersonal life, negative life events, certain illnesses like depression - alcohol abuse - personality and behavioural problems, presence of physical,

emotional and sexual violence, previous history and family history of suicides, long-standing use of alcohol and drugs, unresolving problems in education - occupation and marital life, chronic, debilitating and terminal illnesses and others. In addition, absence or lack of protective factors in an individual like support system, crisis help, coping abilities, decision making skills, communication, resource availability, religious practices, positive outlook and life satisfaction also contribute for the occurrence of suicides.

A passing suicidal thought happens to most of the individuals in a crisis situation. However, not every one passing through this phase would think, attempt or complete the act. Some individuals due to their inability to cope with the stress and also due to lack of adequate support mechanisms, finally find suicide as an option. However, the word option by definition indicates that there are choices. If one considers suicide as a choice, it takes away the options and life even before a solution can be found and put into practice before death. However, many times the causes are multifactoral, repetitive, progressive and time bound. The causes are also specifically interrelated to one another and become cumulative over a period of time.

4. THE IMPACT OF SUICIDES

For every human being committing suicide, the impact experienced by numerous family members, friends and acquaintances are varied and significant. The sudden, unexpected death of a close person often shocks his family, friends and other known people. Such an act will affect a child's healthy growth, marriage, employment and family-social interactions. The stigma associated with suicides is also large that many families change their residence, job, school and other activities. While the real impact is yet to be ascertained, it is estimated that nearly 2-3% of total economic burden is due to suicides. Although the act is over for the person who dies, survivors are often left with many questions. With suicide, the problem, pain, suffering and trauma is merely transferred to those who survive and is experienced by everyone in the society.

5. LEGAL STATUS OF SUICIDES

According to Indian Penal Code Sec 309, attempt at suicide is a punishable offence. However, on 27th April, 1994, the Supreme Court Judgement delivered by two-judge constitution bench headed by Justice B.L. Hansaria declared that the provisions for punishment under section 309 of the Indian Penal Code were unconstitutional. However, two years later on 21st March, 1996 the Supreme Court Judgement delivered by five-judge constitution bench headed by Justice J.S. Verma declared that Attempt to Commit Suicide or its abetment is a penal offence, thus, reversing the earlier judgement. In view of this judgment, suicides in India are considered an offence and draw legal impunity.

6. NEGLECT OF SUICIDES

Even though many lives are lost, many people are hospitalized and the impact is significant, suicides have been one of the most neglected areas. There is little understanding and awareness about the need for preventing suicides. Some of the reasons for this situation are:

- People consider suicide as acts due to "karma, aapatthu, sins of past life, bad time or bad luck". Many families believe that it is beyond their reach to save the life of a person.
- To listen, read or see an act of suicide has become such a day to day event, leading to a sense of apathy. Even though tense and anxious moments are experienced by people, mechanisms on how to prevent such acts are considered only when such an act affects a person known intimately to us. People become serious and inquisitive and attribute suicides to 'individual failures', without realizing that complex etiological factors are actually responsible for the act.
- In many societies, suicides carry large amount of stigma. Hence, it is natural to hide these acts and not to extend it beyond the person or his family. While this is a debatable issue from moral and ethical angles, public and scientific debate on recognizing the problem, identifying solutions and implementing strategies has not occurred.

- Legal complications and police investigation are a component of the stigmatizing process. To avoid these situations, false information and declarations are given for official purposes, thus, burying the real issues.

- Underreporting and misclassification being common in the area of suicides, the real problem is not analyzed in different situations due to lack of scientific information at different levels. Hence, the real burden and causes of the problem are not known clearly.

- The real lack of professional participation in prevention and policy-making issues has been one of the major obstacles to bring suicides out of shadows. Apart from provision and improvement of emergency and hospital care services, the other vital elements have not been addressed by health professionals.

Myth: *If once the thought of suicide comes seriously in an individual, he/she will definitely complete it at some time.*

Fact: *Not everyone who thinks of suicide is likely to repeat the same. However, it has been shown by scientific research that persons with history of attempted suicide are at a greater risk of completing the act over the next few months or in the following year or two. Timely help and support can help the person to get over the death wish for the rest of his/her life.*

- With very few people having access to proper general and mental health services across the length and breadth of the country, suicide prevention has not developed on an intersectoral approach. Hence, instances in district and taluk levels and even in cities, just receive a cursory look at the events.

- Since problem, pattern and causes of suicides are different in Indian cities and towns, a fundamental requirement is the availability of research information on various issues related to suicide. It is known that as long as the suicide phenomenon is not analyzed in different analytical dimensions, efforts towards prevention will be scant and limited.

- "Victim blaming" is a common factor, without understanding that a number of social, environmental, biological, occupational and family related factors play a cumulative

> ***Myth:*** *Asking about suicidal thoughts to some persons may precipitate the act.*
>
> ***Fact:*** *This is not true. In fact, not asking about suicide may prevent identification of a person at high risk of suicide at an early stage.*

and an interactive role in the occurrence of suicides.

7. APPROACHES TO PREVENTION

Since causes of suicides are multifactorial extending to all spheres of life, the answers to prevention must also be multisectoral. From a public health point of view, the major steps towards prevention are identifying the problems in its various dimensions, understanding risk factors, developing interventions focused on risk factors and, identifying what works in individual societies. Implementing these solutions on an integrated, and coordinated platform often helps in reducing the problem, thus improving health of societies. One of the approaches likely to provide long-term solutions is the intersectoral approach (Figure 5). In this approach, the problem is identified in its various facets and inputs are provided by all concerned sectors. With coordinated joint action plans, efforts should be made from all concerned agencies to implement these plans as suicide prevention is everyone's responsibility.

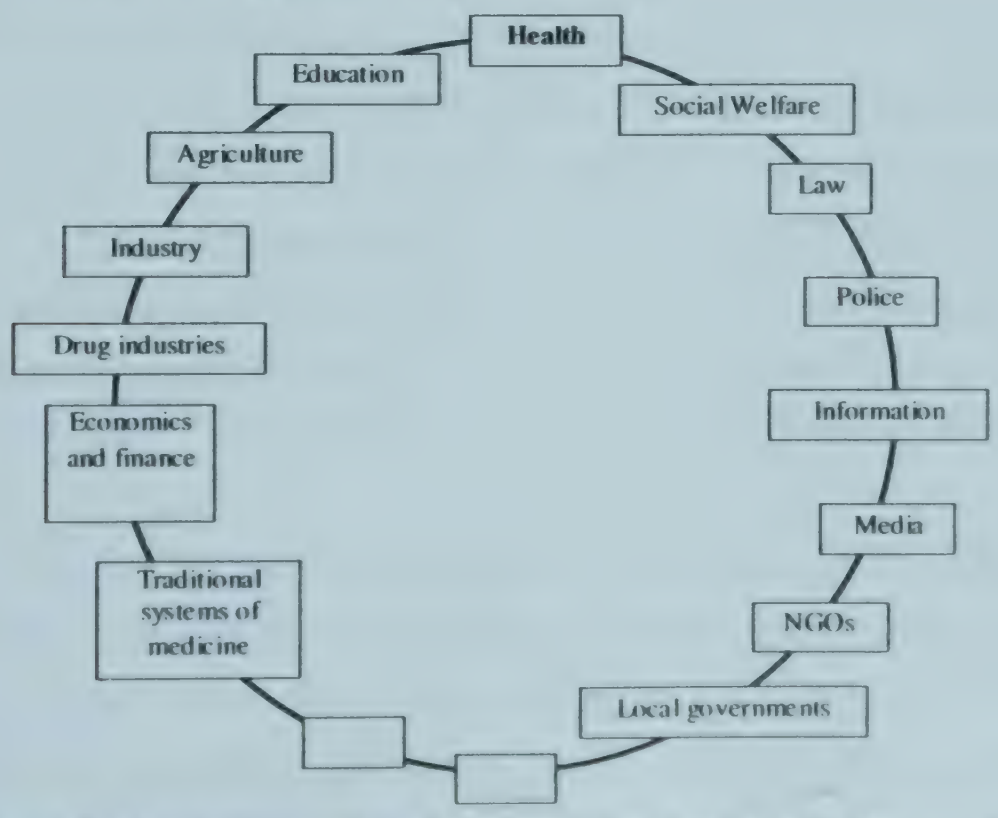

Figure 5: An intersectoral approach to Suicide Prevention

In this approach, health sector has to take a lead role in developing - implementing - evaluating suicide prevention programme as it is a matter of life and death and hence, a health problem. Health Ministries and professionals have to take major responsibilities in guiding and leading other sectors and professionals towards a framework of action for suicide prevention.

As depicted in the figure, suicide prevention strategies have to be developed in all sectors and it is important to identify specific inputs from each of the sectors. Further, intervention changes with the problem on hand (Eg. suicides among children, adults, women).

Myth: *Only poor people who cannot afford basic requirements of life commit suicide.*

Fact: *Suicide is not a problem related to class, age or gender. Depending on the social, environmental, economic or mental health status, anybody can commit suicide. It is seen that suicides among poor people is reported in press more frequently.*

8. TOWARDS CAPACITY BUILDING ACTIVITIES

Investments in diagnosis and management through technological and medical inputs has dominated the health sector for several decades. This is true not only in Bangalore but in every part of the globe. Massive inputs into more doctors, drugs, equipments and related infrastructure has occupied central place in health care delivery system. This has resulted in very little inputs for prevention - policies and research (socio-epidemiological nature), thus resulting in conspicuous absence of culturally relevant - cost-effective - sustainable preventive programmes.

Research during the last two decades all over the world has amply demonstrated that suicides are predictable and preventable. Some of the countries have translated this into action by investing in programmes, relevant manpower and supportive networks. In India and its various corners, interested professionals and those working in suicide prevention are only few. This situation is compounded further as it is not

Myth: *Suicide runs in families. So, nothing can be done.*

Fact: *As per research findings, there Is some association for hereditary basis of suicide. There is a possibility that some mental illnesses which cause suicidal tendencies, occur in families. This general observation is not true for all suicides.*

clear as to what are the programmes likely to result in suicide reduction. The reasons for this are absence of descriptive and analytical information on suicide and lack of manpower to implement and evaluate programmes. In this scenario, strengthening human and institutional capabilities is a key step in the process of capacity building. Capacity building within health promotion is defined as "the development of sustainable skills, structures, resources and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over". Capacity building refers to a set of activities related to creation, expansion or upgradation of a set of desired qualities and resources called capabilities that can be drawn for desired outputs continuously over a period of time. This process refers to equipping professionals from health and related sectors with adequate knowledge - skills - resources - options and useful choices to develop activities on an individual - institutional and a societal basis. Professionals and people need to work together to achieve common goals.

With the problem being enormous and impact being significant, coordinated and concerted actions in the country and in Bangalore city are few and negligible. There is need for bringing people and professionals from different sectors together on a common platform. Sensitization and awareness based on problem definition - identification and roles and responsibilities needs to be carried out across the length and breadth of country and in every city. In order to evolve suitable strategies for- prevention, early diagnosis and management, expansion of after care services and to develop policy responses, NIMHANS, Bangalore, undertook the project "Capacity Building Strategies for Suicide Prevention" with support from World Health Organization and Ministry of Health, Government of India, during the year 2002-03. Under the project, series of workshops were conducted to i) increase awareness among professionals from different sectors, ii) identify what actions can

be developed at different levels to evolve suicide prevention programmes in a collaborative manner with inputs from all sectors and to identify existing barriers to be overcome for suicide prevention programmes. The workshops were conducted for health professionals, non-governmental organizations, educational institutions, police officers, legal agencies, media personnel and other agencies.

In this connection, a workshop for professionals from Woman and Child Development Organizations was held in Bangalore at NIMHANS on October 17, 2002. Nearly forty two people attended the workshop and discussed their role in suicide prevention. (Refer to Annexure I for details of the Workshop). The recommendations and areas requiring action are presented in the following sections. During the course of workshop, several of the issues presented by speakers were discussed in depth by the participants. While significant advances have been made in acute management of suicide survivors, efforts are lacking for prevention programmes. It was felt unanimously that the city of Bangalore needs to address the growing problem of suicides through an intersectoral approach with the participation of a number of agencies. The following recommendations are placed herewith to be included in future programmes.

Myth: *Suicidal persons are always mentally ill.*

Fact: *This is not entirely true. However, a large number of people attempting suicide are depressed, unhappy, sad or violent before the act. Further, mentally ill persons carry higher risk of suicides. But, many physically and mentally healthy people also commit suicide. The inherent desire to live and a battle between "to live" or "not to live", makes these people unhappy before the act.*

FACTS ON COMPLETED SUICIDES IN BANGALORE

- As per national figures, highest number of suicides has been reported from the city of Bangalore.
- Suicides are on the increase in the city of Bangalore currently. During the year 2000, nearly 1,730 persons completed suicides and it is estimated that nearly 15,000 people attempted suicides.
- Maximum number of suicides occurred between 15-29 years (42%) and 30-44 years (31%).
- Suicides are slightly more among men compared with women (M: F::58%:42%).
- Suicides are more frequently registered among lower and middle-income group (80%).
- Nuclear families (94%) had more number of suicides in comparison with joint families.
- Skilled and unskilled workers (24% and 19%) were more, compared to professional and semiprofessional groups.
- Highest number of suicides occurred between 12 noon to 6 pm (34%).
- Alcohol consumption was a major risk factor in 15% of suicides. Among them, 56% were under the influence of alcohol at the time of the act.
- Home and its surroundings were the most common place of occurrence (82%), especially among women (92%).

Contd.....

- Maximum number of suicides occurred when the person was alone at home (56%).
- Nearly 10% had made a previous suicidal attempt in the past.
- An obvious (recorded) mental disorder was present in 9% of suicides.
- Causes of suicide were multifactorial in nature. As per the study, the five major causes among men as per police records were chronic physical illness (32%), family problems (10%), alcohol related problems (14%), financial problems (8%) and unemployment (4%). Among women, major causes were illness (42%), family problems (18%), marital disharmony (5%), frustration in life (4%) and school related problems (3%). The identification of these causes is based on what the family members have reported and real causes could be different.
- The commonly employed methods were hanging (47%), poisoning (31%), self-inflicted burns (18%) and drowning (3%).
- Only 14% of men and 18% of women received first aid (of some type) prior to death.

FACTS ON ATTEMPTED SUICIDES IN BANGALORE

From an analysis of 1260 attempted suicide from 12 hospitals in Bangalore city during 1999, it was estimated that nearly 19,000 persons attempted suicides in the city of Bangalore (Ratio of completed to attempted – 1:10). Further,

- Attempted suicides were most common in the age group of 20-24 years (26%).
- The attempted suicides among men were higher than in women (M:F::53%:47%).
- Maximum number of attempted suicide cases belonged to nuclear families (95%).
- Nearly 98% of attempted suicides occurred in lower and middle socioeconomic groups.
- Attempted suicides occurred mostly among skilled workers (21%) and semiprofessionals (18%).
- Suicides were attempted mostly during evening and night times (45%). Most suicide attempts occurred at home and its vicinity (96%). Suicides at home were higher among women (88%) compared with men (59%).
- Regular consumption of alcohol was documented among 27% of Males and 1.5% of Females. Within this group, 84% of males and all females were under the influence of alcohol at the time of the act.
- Previous History of attempted suicides was higher among men (20%) than in women (14%).

Contd.....

- The commonest mode of attempting suicide was by poisoning (65.5%). The commonly used substances were Metacid (18.7%), Rat poison (18%), Baygon spray (17.1%) and also various neuro-psychiatric drugs (18.6%).

- Among men, the 5 major causes of suicides were: family conflicts (34%), illness (15%), financial problems (14%), alcohol related problems (10%) and job /career accompanied problems (6%). Among women the 5 major causes were: Family conflicts (46.3%), illness (18.8%), marital disharmony (9%), financial difficulties (6%) and love disappointments (4%).

Among attempted suicides, only 58% cases received some type of first aid care prior to reaching the study hospitals. 53.7% of males and 48.8% of females attempting suicides received first aid services. In cases of suicide attempts by burns, 43% of victims did not receive any first aid due to the family's lack of knowledge. 14% of men & 19% of women died within the hospital at various points of time and among burns, 82% of these deaths were due to increased severity.

9. ISSUES AND ACTIONS

- Suicides among adolescents and women account for a large number of deaths as nearly 50% of suicides are by women and a third are among adolescents. The share of women and children has been increasing significantly in recent times.

  NGOs working in this area should take up an active role in sensitising the society about the growing rate of suicides among women and adolescents and the causes for this situation in terms of the problems faced by them in various facets of life. Awareness needs to be created among the public about their role in preventing the social problems which compel women and adolescents to commit suicide. There should also be sharing of information among the various NGOs working in the area of development and welfare of women and children, so that a concerted and effective effort in preventing suicides can be developed.

- Women and children belong to the neglected groups of our society due to socio-cultural issues.

  Women and children are more susceptible to ill-treatment, abuse and social evils, due to their being physically, psychologically and biologically at variance compared to men and hence they are more victimised. Hence, NGOs should take up an active role in improving the status of women and children, especially in the lower classes of the society, so that they are provided with the right opportunities for growth and to be independent financially and socially.

- Inequality of women in society in various areas has resulted in denial of opportunities in various facets of life, including education, jobs, marriage and family, etc. They also suffer due to economic disparities, with their earning power being lesser than that of males. The social role of women in family after her marriage also places an additional emotional and psychological burden

to initially adjust to her husband's family, and later to support her new home and family in both ways, financially and domestically. Further, a woman is also biologically more predisposed to vulnerability compared to men.

NGOs need to work towards the empowerment of women, in all areas including education and occupational opportunities. Women should be trained to protect and take care of themselves so that they need not consider themselves to be weaker. Awareness has to be created among the public about the importance of the woman in the family. Also, she should be given sufficient time and support to adjust to her spouse's family and effectively fulfil her roles and responsibilities.

- Childhood and adolescence is a vulnerable age, both physically and psychologically. Children and adolescents are not only physically weaker compared to an adult, but also face a lot of emotional turmoil and internal conflicts in this formative phase of their life. This is when children need the most guidance and support, so that they grow up to be strong and successful individuals (not just in academic terms alone) in society. They have a lot of growing dreams and aspirations. When any of their dreams or aspirations are thwarted, adolescents can become rebellious, and in extreme cases attempt suicide.

  The government and NGOs should take up the onus of educating parents and teachers on the right ways of bringing up children by focussing on the overall development of the child rather than stressing only on academic performance. Counselling services should be made available in schools and colleges, thus building a strong support structure for children so that they have a place when they are in distress. In addition, education has to focus on values and move away from grades / marks / ranks.

- A large number of NGOs have been working at grass root levels on number of specific issues like domestic violence, rights of women, elimination of caste systems, empowering of women, rights of children, problems of street children, issues related to destitutes, orphans, etc. There is a need for joint and

concreted action as all these problems can sometimes be causes for suicides.

There is a need for joint interaction of NGOs on common issues and problems. NGOs at grass root levels are closer to community and are activists with an ability to influence local governments. Suicide prevention must be a common agenda for all these agencies.

- Since NGO representatives or staff work in close contact with individuals and families, they can offer immediate help.

  All NGOs and their staff must be familiar with warning signs of suicide-simple ways of non-judgmental listening-making appropriate referrals and providing simple continuity in follow up care. District-wise programmes need to be organized through state level bodies like 'Voluntary Health Association of Karnataka' and 'Voluntary Health Association of India' in the coming months.

- Other specific issues in the Indian sub-continent contributing to the causation of suicides are dowry system, social inequalities, farmers' distress due to crop failure and suicides due to social and political reasons.

  Social and legal reforms need to be undertaken in order to curb these problems, which is a menace to the society, by the society. The Government and NGOs should work in this direction to reduce these evils by educating the masses and also working in coordination with various government agencies and policy makers. The existing laws should be enforced appropriately and existing laws should be made more strict, thus creating a healthy social and cultural environment. This can also act as a deterrent amongst people to desist from committing such crimes. Specific strategies need to be evolved for focussed problems in a broader framework of social, health and welfare programmes.

- Currently, there are not sufficient number of dedicated and committed NGOs working in the area of women and child development.

  The message of empowerment of children and women is not

Individuals at high risk

Since suicide is a widespread non-random phenomenon in every society, it is important to develop measures for early identification. While no general symptoms and signs as applicable to other health problems are found, research till date indicates that it is possible to identify people at high risk of suicides. Since these people are all around us, special efforts should be made to identify them and provide timely help. These individuals are those experiencing the following thoughts and ideas.

Thinking and feeling

- *repeating that "destiny is calling them", "hearing words from God", or "joining a known person in heaven", "I cannot go on", "I am planning to die", "enough of this life", etc.*
- *feelings of extreme self-hatred, feeling guilty, worthless or ashamed.*
- *feeling of loneliness, helplessness, hopelessness and worthlessness.*

Behaviours

- *complaining of "persistent boredom", inertia, lethargy and "don't know what to do" with decreasing interest in hobbies, sex, and other activities which they enjoyed earlier.*
- *participating in excessive religious activities, significantly more than previously observed or not participating in religious activities in which they were participating earlier.*
- *expressing loss of confidence, self-esteem and faith, loneliness, anxiety, etc.*
- *having withdrawn behavior and inability to relate to family and friends.*

Changes perceived by self or observed by others

- *having conflicts within themselves or with other members of the family on a continual basis, of a non-resolving nature.*
- *with a history of previous suicidal attempt(s).*

- *with a change in personality - showing irritability, pessimism, depression, apathy, anger or violence along with a change in their eating or sleeping habits; crying spells, sudden desire to tidy up personal affairs, writing a will etc.; writing suicide notes, songs and stories.*
- *repeated mention of death or suicide on a regular basis.*

Situations

- *too much pressurized by family for economic and other gains (such as dowry, or high achievement in academics).*
- *experiencing recent loss of a person due to death, violence, separation or a broken relationship.*
- *losing their status, jobs and income - suddenly.*
- *recently discharged from hospitals (and those staying at home), with mental disorders or other terminal illnesses (such as cancer, HIV/AIDS, tuberculosis and congenital health problems, etc.,) or those currently suffering from any psychiatric illness - specially depression and alcohol abuse.*
- *facing sudden economic loss due to migration, crop failure, economic upheaval, loss of day- to-day livelihood, natural disasters and others.*
- *Experiencing excessive/intolerable physical abuse/sexual abuse/ emotional abuse.*
- *Having sudden failures in life, examinations, severe property losses, etc.*
- *with a recent family history of suicide.*

percolating through all strata of society due to inadequate number of NGOs working in this area. Apart from a more effective role of NGOs currently working in these areas, new NGOs should come up and they should have a more focussed and rigorous role in making people aware of these issues. Further, there is need for networking among NGOs to bring in joint action oriented programs.

- Current Government programmes to help children and women in distress haven't been very successful due to most people being ignorant about the existence of these programs.

  Government apart from initiating such programmes, must publicize them so that they can be utilised to their maximum potential. Such information should be widely disseminated, for e.g., notices of information of these programmes can be put up on Zilla Parishad notice boards so that it can be read by the general public and made use of. Greater dissemination should be undertaken by media agencies on government programmes.

List of Bangalore Helplines

Vanitha Sahaya Vani	1091
Elders Helpline	1090
Makkala Sahayavani	1098
HIV/AIDS Helpline	1097
SAHAI - Suicide Prevention Helpline	5497777
Women's Police Cell	2290028
Women's Voice	2214478
Vimochana	5496934

- Persons working in the area of women and child development do not receive appropriate and adequate training.

  There is a need for proper training of the persons working in the area of women and child development on their various responsibilities including counselling techniques, so that they are

able to handle the problems of women and children approaching them more effectively. This would also help them to be well equipped with strategies for suicide prevention.

- NGOs currently are working in specific areas only.

  The need for NGOs to take up a wider role in several areas cannot be overemphasised. They should spread their wings not only in the area that their current work involves, but also across other areas, so that it is easier to handle issues like suicide. These NGOs actively participate in suicide prevention as it is a well-documented fact that suicides never occur due to a single factor alone. While focussing on specific areas does help effective delivery of their intended aims, a wider and holistic view and awareness that can be achieved by working together will help each of these organisations in better achieving their goals of helping women and children.

- Current workshops have focussed mostly on people working in various sectors like health professionals, family physicians, NGOs, and college teachers etc., and for people working on suicide prevention at the grass-root levels. Policy makers and officials have not been included in the purview of these workshops.

  The participants of the workshop felt that an inter-sectoral approach was very important in prevention of suicide as it cuts across all sections of people and hence a single workshop involving the various sectors like media, policy makers, NGOs, healthcare personnel, police and legal personnel should be held. The participants also strongly felt the need for a workshop for policy makers as they are responsible for taking vital decisions regarding the various laws and policies concerning suicide prevention.

Know more about organizations offering supportive services in Suicide Prevention in India.
(All the agencies offer services through telephone, face to face counselling and through postal correspondence)

The Samaritans - Sahara

'Sevaniketan', Sir J.J. Road, Byculla Bridge

MUMBAI 400 008

Tel: +91-22-307 3451

Lifeline Foundation

2/8 A, Sarat Bose Road

KOLKATA 700 020

Tel: +91-33-474 5255 or 474 5886

Website: http://education.vsnl.com/n4h/

Sumaitri

NDMC Complex 1st floor

48 Babar Road, Nr. Bengali Market

NEW DELHI 110 001

Tel: +91-11-371 0763

Website: http://www.sumaitri.org

Maithri

Vimalalayam Building, Ashir Bhavan Road

Kaceripadi, **KOCHI** 682 018

Tel: +91-484-396 272 or 396 273

Sneha
7, Avvai Shanmugam Lane, (Lloyds Lane), Royapettah
CHENNAI 600 014
Tel: +91-44-811 5050
Website: http://www.webindia.com/np/india/sneha.html

Saath
B12 Nilamber Complex, H.L. Commerce College Road
Navrangpura, **AHMEDABAD** 380 009
Tel: +91-79-630 5544

Aasra
A-4, Tanwar View, CHS,
Plot NO - 43, Sector 7, Koparkhairane
NAVI MUMBAI 400 709
Tel: +91-22-754 6669

Maitreyi
255 Thyagumudali Street
PONDICHERRY 605001
Tel: +91-413-339 999

Roshni
70, Paigah Colony, Behind Anand Cinema,
S.P. Road,
SECUNDERABAD 500003
Tel: +91 40 790 4646

Prerana
For Suicide Prevention & Crisis Intervention
Om Prakash Villa, Off Devi Dayal Road, Mulund (W),
MUMBAI 400 080.
Tel. : 590 5959

Some organizations working in Bangalore to help individuals with suicidal thoughts and behaviours are:

Medico Pastoral Association
47, Pottery Road, Frazer Town
Bangalore
Tel: +91 80 5497777

Janodaya
3, 9th Cross, 5th Main,
Jayamahal Extn, Bangalore 46
Tel: 3332564

Police Counseling Cell
Vanitha Sahaya Vani,
Police Commissioner's Office,
Infantry Road, Bangalore 01
Tel: 1091, 2942865

APSA
Namma Mane, # 34,
Annasandra Palya, Vimanapura Post
Bangalore 17
Tel: 5231719, 5232749

Parivarthan
3310, 8th Cross, 13th Main,
HAL II Stage,
Bangalore 08
Tel: 5298686

Vathsalaya Charitable Trust
246, 8th E Main, HRBR Layout,
Banaswadi,
Bangalore 43
Tel: 5457360, 5452749

CREST
Kasturinagar, 3rd D Cross,
Bangalore 16
Tel: 5453076

Karuna Mother Theresa Home
2, 2nd Cross, Silver Jubilee Park Road,
Bangalore 02
Tel: 2217463

Mahila Dakshata Samithi
66/A, Sanjaynagar Main Road,
Bangalore 94
Tel: 3410042

Sumangali Seva Ashram
Cholanayakanahalli,
RT Nagar Post,
Bangalore 32
Tel: 3439190

St. Michael's Convent
80 ft Road,
Indiranagar,
Bangalore 38
Tel: 5282811, 5252406

Banjara Group- Banjara Academy
Helping Hand
418, 1st Main 1st Block, R.T Nagar,
Bangalore 32
Tel: 3535787, 3535766

Vishwas
17th Main, HAL 2nd Stage
Indiranagar
Bangalore
Tel: 5272705

Richmond Fellowship Society of India
Asha, 501, 47th Cross, 9th Main
V Block, Jayanagar, Bangalore 41
Tel: 6645583, 6346734

Psychiatry Departments of Major Hospitals and Contact Persons

St. Martha's Hospital
Nrupathunga Road
Bangalore-5600 01
Ph.2275081
(Contact person: Dr. Ajit Bhide)

Kempegowda Institute of Medical Sciences
K.R. Road, V.V. Puram
Bangalore-560004
(Contact person: Dr.Ashalatha)

Victoria Hospital
Bangalore Medical College
Fort, Near Market
Bangalore-560 002
(Contact persons: Dr. Chandrashekar, Dr. Prashanth)

M.S. Ramaiah Medical College and Hospital
New BEL Road
Bangalore-560054
(Contact person: Dr. Ghorpade)

Dr. B.R. Ambedkar Medical College and Hospital
Kadurgondanahalli
Bangalore-560045.
(Contact person: Dr. Hiremath)

Bangalore Baptist Hospital
Bellary Road, Hebbal
Bangalore-560024
Ph: 3330321
(Contact person: Dr. Meera Balraj)

St. John's Medical College and Hospital
Sarjapur Road
Bangalore-560034
(Contact persons: Dr. Prakash Appaiah, Dr. Sheila Daniel and Dr. Manohari)

National Institute of Mental Health and Neuro Sciences
Hosur Road, Bangalore 560 029
Ph: 6995000
(Contact person: Dr. C.R. Chandrashekar)

Know more about research - prevention - policy issues from:

National Crime Record Bureau
Ministry of Home Affairs
Government of India
East Block - 7, RK Puram
New Delhi 110 066
Tel: 6172324, 6177427
Email: ncrb@nda.vsnl.net.in
Website: www.ncrbindia.org

National Institute of Mental Health And Neuro Sciences
Hosur Road
PO Box No. 2290, Bangalore 560 029
Karnataka
Website: www.nimhans.kar.nic.in

Institute of Human Behaviour and Allied Sciences
GT Road, Dilshad Garden,
PO Box 9520,
New Delhi 110 095
Website: http://delhigovt.nic.in/dept/health/healfr.htm?ihbas.htm

Indian Council of Medical Research
V. Ramalingaswami Bhawan,
Ansari Nagar,
New Delhi - 110 029, India
Website: icmrhqds@sansad.nic.in
Tel: 6963980, 6962794, 6962895, 6560707, 6560234
Fax: 6868662, 6856713

Thrani Center for Crisis Control
Thiruvananthapuram, **Kerala**, India - 695 037
Cell: ++91-98461-35003 Tel: ++91-471-300333 / 300334
Email: thrani@yahoo.com
Website: http://www.geocities.com/thrani/article.htm

International Organizations working in the area of Suicide Prevention

American Foundation for Suicide Prevention
120 Wall Street, 22nd Floor
New York, New York 10005
United States of America
TOLL-FREE: 888-333-AFSP
Tel: (212) 363-3500
Email: inquiry@afsp.org
Website: www.afsp.org

American Association of Suicidology
4201 Connecticut Ave., NW
Suite 408, Washington, DC 20008
United States of America
Tel: (202) 237-2280
Website: www.suicidology.org

Befrienders International
26/27 Market Place
Kingston upon Thames
Surrey KT1 1JH
United Kingdom
Tel: +44(0) 20 8541 4949
Website: www.befrienders.org

International Association for Suicide Prevention
I.A.S.P. Central Administrative Office
Le Barade, F-32330 Gondrin
France
Tel: +33 562 29 11 42
Email: iasp@aol.com
Website: www.iasp1960.org

Samaritans
The Upper Mill, Kingston Road
Ewel, Surrey
KT17 2AF
United Kingdom
Tel: 020 8394 8300
Email: admin@samaritans.org

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Australian Institute for Suicide Research and Prevention
Griffith University - Mt Gravatt Campus
Brisbane - Queensland 4111
Australia
Website: http://www.gu.edu.au/school/psy/aisrap/

Universitäts Nervenklinik, University of Wuerzburg
Füchsleinstr.15, 97080 Würzburg
Germany
Tel: +49-(0)931-203-248
Email: clips-psychiatry@mail.uni-wuerzburg.de
Website: http://www.uni-wuerzburg.de/IASR/

World Health Organization
Avenue Appia 20, 1211 Geneva 27
Switzerland
Tel: (+ 41 22) 791 21 11
Website: www.who.int

World Health Organization: South East Asia Regional Office
Nirman Bhawan, Room 534, 'A' Wing
Maulana Azad Road
New Delhi 110011
Tel: +91 (11) 23370804/ 23370809
Website: www.whosea.org

Canadian Association for Suicide Prevention
c/o The Support Network
#301, 11456 Jasper Avenue
Edmonton, Alberta T5K 0M1
Canada
Tel: (780) 482-0198
Email: casp@suicideprevention.ca

Centre for Suicide Research
Department of Psychiatry
University of Oxford, Warneford Hospital,
Oxford OX3 7JX
United Kingdom
Tel: 44 (0) 1865 226258
Email: csr@psych.ox.ac.uk
Website: www.psychiatry.ox.ac.uk/csr

ANNEXURE-I

Proceedings of the Workshop On

"Suicide Prevention - Capacity Building Strategies" For Woman and Child Development Organisations

Held on October 17th, 2002

At National Institute of Mental Health and Neuro Sciences, Bangalore - 29

Considering the fact that suicides have emerged as a major public health and developmental problem and also bearing in mind that it is the police who develop the first contact with the survivors of a suicide, a workshop on "Suicide Prevention: Capacity Building Strategies" for the Woman and Child Development Organisations of Bangalore city was held at the National Institute of Mental Health and Neuro Sciences, Bangalore, on October 17th, 2002. The workshop was sponsored by World Health Organisation, New Delhi, and Ministry of Health, Government of India. About 45 representatives from various woman, child and community development organizations participated actively in the discussions to evolve various strategies for prevention of suicides. The workshop was very useful as the participants and resource persons had diverse but in-depth knowledge in the subject of suicide prevention. The resource team included faculty of NIMHANS (Dr. Gururaj G. and Dr. Mohan K. Isaac) and the Assistant Director of the Department of Woman and Child Welfare, Government of Karnataka (Ms. Chandra).

The workshop consisted of lectures on the various facets of suicide with communicative interaction between the resource persons and the participants. In her inaugural address, Prof. M. Gourie Devi, Director and Vice-Chancellor, NIMHANS, felt that suicide is not just a social problem but a huge health problem affecting all communities and hence the need to prevent this immediately. She spoke about the situation in Kerala, which is the state with maximum number of suicides in India. Also, Bangalore is the Indian city with maximum number of suicides. She compared this situation with a state like Bihar which is considered backward with low literacy rates and which has the least reported suicides. She said this discrepancy might be merely due to faulty reporting systems in backward states where suicides are not reported properly. She also emphasised on the fact that the phenomenon of suicide and its associated factors should be looked into

in-depth and not just on a superficial plane. For example, as Bangalore is considered the Information Technology capital of India, it cannot be inferred that developments in Information Technology causes suicides. She also spoke about the various factors which would drive a person to suicide: for e.g., poverty where entire families commit suicide; students who end their life as they are unable to cope with increasing competition, peer pressure and parental pressure; alcoholism due to which not only the alcoholic men commit suicide, but their wives also do due to difficulty in coping with the situation; and problems of aging due to feeling of isolation, diseases which may be either incurable or chronic in nature. She concluded by saying that looking at the current rise in suicides, even if each one of us can prevent one suicide, then the mission of preventing suicides is accomplished.

Dr. Gururaj G., Professor and Head, Department of Epidemiology, NIMHANS, spoke about the epidemiological aspects of the problem of suicides. He presented the findings of the recent study undertaken by NIMHANS in collaboration with Bangalore city police along with 12 major hospitals and media reports. This study showed that suicides were more common among the younger age groups, especially 15-45 years with an almost equal incidence among men and women- M:F::1.2:1. It was estimated that almost 2000 people completed suicide, while about 19,000 people attempted suicide every year in Bangalore city alone. Bangalore has shown a 3-time increase in the incidence of suicides in the last one decade i.e., from 1990 to 1999. While hanging was the commonest method of completed suicide, poisoning was the most predominant method of attempted suicide. Also, self-immolation was seen to be quite prevalent among young married women. Major causes of suicide were linked to illness, family disharmony, financial problems, marriage and school related issues, work related problems, frustration in life and others. He addressed the problem of suicides specifically among children and women and the various ways and means of preventing the same. Dr. Gururaj then spoke about a few case studies in order to delineate the pathways of an act of suicide. To conclude his talk, he described the various warning signs and approaches for prevention of suicides.

Dr. Chandra, Assistant Director, Department of Woman and Child Welfare spoke about the various activities and programs undertaken by the State Government. She said that the emphasis was mainly on the education of girls, as a part of which attendance scholarships were given to girls studying in classes V to X from 8 districts identified to be having low literacy rates. Also, the Government had set up 14 girls' hostels, of which 8 are run by NGOs and the rest manned by the

Government. These hostels accommodate girls studying in classes VI to X, and offer shelter for students in job oriented courses and polytechnic courses. Scholarships are provided for children of prisoners. In addition to this, they have facilities for institutional care.

A scheme called "Santhwana" was sanctioned by the Government of Karnataka in 2001 with the objective of assisting women, who are victims of various atrocities such as rape, sexual harassment, dowry and domestic violence and those who are in difficult circumstances. The assistance gives ranges from immediate relief to rehabilitation to make them confident and self-reliant. Santhwana Centres are established in districts and in selected taluks and each centre has a helpline. 44 helplines for women are currently operating in 26 districts of Karnataka, except Chitradurga. Of these, 16 are in taluks and the rest are in districts. These are toll-free lines with a common number-1091. In Bangalore, currently there are 3 helplines, one each in the Police Commissioner's Office, Bharathiya Grameena Vidya Samsthe and Janodaya Samsthe, of which only the first one has the phone number 1091. There is a provision for employing 3 social workers and 1 family counsellor for each of these helplines. These helplines work for 24 hours a day each person working for 8 hours on a shift basis.

Women requiring immediate protection could be sent to short stay homes, state homes or reception centres. Also, they can be accommodated in Working Women's Hostels, which are 70 in number all over the state. Counselling services and legal assistance is provided. For women requiring immediate financial support, money ranging from Rs. 2000 - Rs. 10,000 can be provided depending on the decision made by the District Commissioner. Education is also provided to girls who are interested. In case of death of a woman due to any atrocity, her children are provided with financial support (Rs. 5000 - Rs. 10,000) which is kept in a fixed deposit in a nationalised bank and used for education and rehabilitation of the children. The Karnataka State Women's Development Corporation will help such women recommended by the Santhwana Centres to undergo skill development training and to take up self-employment under different schemes. About 1290 women have been assisted through the Santhwana Program till now.

The 'Sthree Shakti Program' is another program consisting of forming self-help groups and empowering women at village level. Each group consists of 10-20 women who belong to similar income group, caste etc. These ladies meet once a week,

save money and involve in internal lending in order to help one another.

The department of woman and child welfare has also undertaken self-employment programs for women called 'Mane Belaku' and 'Udyogini'. They also conduct various training programs in the field of computers, marketing and entrepreneurship.

SGSY programs are being taken up in beneficiaries who are urban slum dwellers. Karnataka Mahila Abhivruddhi Yojana currently has 278 programs, of which 1/3rd of the budget is compulsorily allocated to women. Another program called 'Jagruthi' is being held in some districts, where awareness is created among girls upto 14 years and bicycles are provided to these girls so that they can inturn create awareness among the villagers.

Dr. Mohan K. Isaac, Professor, Dept. of Psychiatry, NIMHANS, spoke about the various strategies and approaches towards prevention of suicides. He raised some important questions: should suicides be prevented at all; if yes, can they be prevented and what do we know about suicide prevention. While everybody unanimously agreed that suicides have to be prevented and can be prevented, the participants also came out with various strategies for prevention of suicides like effective listening, counselling, changing the system of education and creating awareness, effective communication, acceptance and tolerance towards fellow humans, strengthening of family and community.

Dr. Isaac emphasised that inspite of suicide being a universal phenomenon, the approaches towards prevention were different in the developed and developing countries. In the West, emphasis is laid on improving psychiatric care like identification and management of depressive and personality disorders and alcoholics. Reducing the issue of licence for fire arms was one of the most common mode of suicide prevention as guns contribute for a majority of suicides. In India, dowry is a major cause for suicide and self-immolation is a common mode of suicide which are unheard of in the West. He then mentioned some of the important strategies towards suicide prevention like (i) reducing accessibility to suicide methods by limiting easy availability of pesticides and other organophosphorus compounds and drugs, (ii) protection of locations in high rise buildings from where people could easily jump off; (iii) changing the media reporting methods where usually suicides are sensationalised causing a lot of copy-cat suicides. As communication on TV channels is mainly aimed at children

and young adults, who are at an impressionable age, this should be changed and to help these people to develop positive attitudes and values. The other important strategies were (iv) awareness building about the various myths and misconceptions on suicides and about (v) destigmatisation. He said that thoughts of suicide were normal and the person should not be considered as mentally ill. He also stressed (vi) on the role of Non-governmental Organisations in the prevention of suicides. He said that one should be conscious to the behavioural changes of people around, listen empathetically, keep advising to the barest minimum, help the person to look at the various options and also identify high risk groups and situations and intervene accordingly.

In all the sessions, there was an intense discussion on future strategies for prevention of suicides. The workshop participants adopted the following recommendations for implementation by the various sectors, especially organisations working in the area of woman and child development.

1. Currently all the workshops that have been conducted have been for groups of people who work at the grass-root level in the area of suicide prevention. The participants of the workshop felt that an intersectoral approach was very important in prevention of suicide as it cuts across all sections of people and hence a single workshop involving the various sectors like media, policy makers, NGOs, health personnel, police and legal personnel should be held. The participants also strongly felt the need for a workshop for the Policy makers as they were the persons who take vital decisions regarding the various laws and policies concerning suicide prevention.
2. The current education system is mostly oriented towards academia and not on the over all development of the child. This leads to very high levels of unhealthy competition, without the children imbibing effective skills to face life. This system should be changed & importance should be given towards inculcating the right values in children & building their inner strength, rather than focusing just on studies. Life skills education should be made compulsory in all schools and colleges. Also, counsellors must be made available in every educational institution for the children to share their problems with and find effective solutions for themselves.
3. Currently, medical education focuses mainly on physical illnesses alone with very little attention given to mental health and its importance. Greater emphasis

should be placed on importance of mental health and strategies for prevention of suicides should be incorporated, mainly as medical professionals need to know how to identify mental illness. It is also a known fact that medical students themselves face a very high degree of stress and this makes them more prone for suicides.

4. Presently, suicide is considered as an offence, legally. This has resulted in decreased numbers of people approaching professionals for help and also in false and low reporting rates. Immediate changes are required with regard to the existing laws of suicides towards decriminalization of the act. The workshop identified that the existing laws are often more barriers to people for registering, reporting, seeking help and thus, increasing the stigma surrounding suicides.

5. In the Indian scenario, there is a lot of stigma associated with mental illness and hence, inspite of very good help being available, people do not approach the mental health professionals. This system has to be changed by educating the people about the importance of mental health and also destigmatising mental illnesses. This would help in improved identification and treatment of mental illnesses.

6. Media, currently hype up suicides and portray them as heroic deeds. Sensationalization of suicides and increased publicity to celebrity suicides should be stopped immediately. The method of media reporting has to be changed. Suicides should be portrayed as negative events which one should not be venturing.

7. The participants identified the importance of counseling in prevention of suicides. Many of the persons who attempt/ commit suicide often internalize their problems and if given a chance to give vent to their feelings and emotions, they might very well come out of these thoughts of suicide. Hence, persons should be encouraged to approach counselors and share their problems.

8. According to the study conducted at NIMHANS, family problem was one of the major risk factors for suicide. The participants identified the need for family education and counseling in order to strengthen family systems.

ANNEXURE II

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Know more about suicide research and prevention initiatives in Bangalore

- Gururaj G & Issac MK, Epidemiology of Suicides in Bangalore, NIMHANS, Bangalore. Publication No. 43, 2001
- Gururaj G & Isaac MK, Suicides .... beyond numbers, NIMHANS, Bangalore Publication No. 44, 2001
- Gururaj G, Ahsan MN, Isaac MK, et al., Celebrate life: Suicide Prevention-Emerging from darkness. World Health Organization: Regional Office for South East Asia, New Delhi, 2001
- Report of the project: "Identification of risk factors and capacity building measures for prevention of suicides" funded by World Health Organization, Regional Office for South East Asia, New Delhi
- Reports of the workshops on "Suicide Prevention- capacity building strategies" - 7 information book series:
  - Information for Health Professionals
  - Information for Non-Governmental Organizations
  - Information for Educational Institutions
  - Information for Family Physicians
  - Information for Police Personnel
  - Information for Woman and Child Development Organizations
  - Information for Media Professionals

SAHAI - Suicide Prevention Helpline

SAHAI

LIFE. YOU'RE WORTH IT

5497777

If you are leading or are a member of an organizatio working for women and children, you could

- Incorporate suicide prevention in your broad framework of activities
- Disseminate information on existing government welfare programmes
- Inform about myths and facts of suicide and thus help to destigmatise suicides
- Strengthen existing laws and reforms by involving local communities
- Help local schools and colleges to develop life skills development programmes
- Network with local hospitals and mental health professionals for
  - early identification
  - management and referral, and
  - follow-up of persons at high risk of suicides
- Develop local programmes for individuals with alcohol problem, destitutes and lowe income group members
- Undertake research by "Eyes and Ears - Open Approach" to gain bette understanding of suicide problem in your area
- Communicate with media to provide right type of information
- Influence local politicians and policy makers to implement programmes to reac beneficiaries